cross sectional study was conducted using state level data from the 2009-2010 National Survey of Children with Special Health Care Needs (NS-CSHCN) from 50 states and DC. Difficulty accessing services was assessed via caregiver reported unavailability of services in the state (N = 18,654) and difficulty getting appointments due to backlogs/waiting lists/other reasons (N = 18,675). Individual level covariates included: caregiver education level, household income, and child's functional ability. State level covariates included state median annual household income and state CAP workforce per 10,000 state youth. Generalized Linear Latent and Mixed Model (GLLAMM) procedure was used to conduct a multilevel logistic regression (with random intercepts) and account for survey weights. **RESULTS: AVAILABILITY:** A $1000 increase in median annual household income was associated with greater likelihood of reporting unavailability of services (AOR = 1.03, 95% CI = 1.02-1.03). A one unit increase in number of CAP per 10,000 youth in the state was associated with decreased likelihood of caregivers reporting difficulty using services due to unavailability of services (AOR = 0.99, 95% CI = 0.98-0.99). **APPOINTMENTS:** With increase in every $1,000 in the state median household income, the likelihood of caregiver reported difficulty using services due to appointments increased significantly (AOR = 1.01, 95% CI = 1.01-1.01). State CAP workforce was not found to be associated with caregiver reported difficulty in getting appointments.**CONCLUSIONS:** State contextual factors such as CAP workforce may have an impact on caregiver reported unavailability of services in the state for children with mental health care needs.

PHS122
RECEIPT OF COLORECTAL CANCER (CRC) SCREENING AMONG MEDICARE BENEFICIARIES WITH SENSORY IMPAIRMENT

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OBJECTIVES: Sensory impaired individuals may face various structural and psychological barriers to access health care services compared to non-impaired individuals. Using CRC screening as a case study, the aim of this study was to determine whether there are differences in CRC screening rates between sensory impaired beneficiaries and beneficiaries without sensory impairment, and to determine what type of CRC screening they chose given the impairment. **METHODS:** We analyzed community-dwelling patients aged 50-75 years from the 2005 Medicare Current Beneficiary Survey (MCBS) access to care files. A modified Poisson regression model was used to test the impact of sensory impairment on rates of CRC screening. Two self-reported screening tests were used. The first was whether the patient 'ever had a colonoscopy or sigmoidoscopy' and the second was whether the patient 'ever had a fecal occult blood test (FOBT).' Chi-Square test was used to examine differences between the sensory impaired and non-impaired groups and to summarize key categorical variables. **RESULTS:** Among 6,494 Medicare beneficiaries, 1,810 (28%) reported some sort of vision impairment and 1,911 (29%) reported some sort of hearing impairment. Multivariate regression models showed that beneficiaries with hearing impairment were 9% more likely to screen using any CRC screening method (RR: 1.09; 95% CI: 1.06-1.13) whereas beneficiaries with vision impairment were as likely as those with no impairment to use any CRC screening method (RR: 1.01; 95% CI: 0.98-1.05). Among those who screened for CRC, beneficiaries with any type of sensory impairment were indifferent between FOBT and colonoscopy (Hearing impairment: RR: 1.10; 95% CI: 0.99-1.23); vision impairment: RR: 1.03; 95% CI: 0.92-1.15). **CONCLUSIONS:** Beneficiaries with sensory impairment are more than or at least as likely as beneficiaries without sensory impairment to screen for CRC. Future studies should examine mediators and facilitators for CRC screening.

PHS123
DO CHILDREN WITH SPECIAL NEEDS RECEIVING CARE COORDINATION HAVE GREATER ACCESS TO PRIMARY CARE?

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OBJECTIVES: North Carolina's child service coordination program (CSC), now known as care coordination for children (CC4C), provides access to preventive and supportive primary care services to children at risk or children diagnosed with a qualifying condition of special needs. The objectives of this study were to characterize CSC recipients and to assess whether CSC recipients had greater access to health care services in the Medicaid program. **METHODS:** Medicaid administrative claims data for a random sample of 7,467 births that matched with a Medicaid eligible mother's record were drawn over a period of two years between October 2008 and September 2010. CSC eligible infants were identified using applicable ICD-9-CM codes. Infants' frequency of health service utilization during first year of life was calculated. Descriptive statistics and multivariate negative binomial regression models, controlled for potential confounders, were performed to compare the health care service use between qualified CSC and non-CSC infants using SAS statistical software (v9.3) at a priori significance level of 0.05. **RESULTS:** A total of 636 infants (8.5%) had a reported diagnosis of one of the qualifying conditions. Most frequent diagnoses were other specified suspected condition (59.1%), interpersonal problems (44.8%), family circumstances (32.4%), and health problems within family (22.8%). A majority of qualified infants (n=538, 84.6%) received at least some CSC services at any time during study period. Infants who received CSC had significantly higher number of well-child primary care visits (mean=6.9) compared to those who did not (mean=5.8) (estimated β=0.17, 95%Confidence Interval: 0.06-0.28). Number of emergency room visits and inpatient admissions did not differ significantly. **CONCLUSIONS:** The results of this study indicate that North Carolina's CSC program provided care coordination services to a large proportion of infants with special needs. Significantly higher number of well-child visits in the CSC group shows greater access to primary care for needy infants receiving care coordination.

PHS124
THE TREND OF CROSS-BOUNDARY FLOW OF EMERGENT CARE IN TAIWAN, 2000–2010

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OBJECTIVES: To evaluate the emergent care resource enhancement policy by investigating the trend of cross-boundary emergent care (CBEC) flows from 2000 to 2010 among 50 subregions in Taiwan. **METHODS:** Approximately 2 million randomly sampled representative beneficiaries from the National Health Insurance database were used as the data source. A modified New York University algorithm was applied to classify emergency department (ED) visits into emergent care, as well as ED visits resulting in hospitalization. Subsequently, 50 medical subregions were used as the analytical units to calculate the proportion of CBEC visits between 2000 and 2010 in Taiwan. Paired t tests were applied to examine the differences in CBEC flow over one decade, and the ratio of the third quartile (Q_3) to the first quartile (Q_1) was presented to reflect the regional variation in CBEC flow. Finally, the 50 subregions were divided into low, medium, and high groups according to their CBEC flows in 2000, and the differences in the CBEC and emergent care capacities between 2000 and 2010 were compared. **RESULTS:** The average proportion of CBEC visits nonsignificantly declined from 42.5% in 2000 to 41.2% in 2010. The Q_3 to Q_1 ratio slightly decreased from 2.18 to 2.13 in that decade. However, the CBEC flow in the subregions in high CBEC groups significantly decreased, accompanied by a significant increase in emergent care capacity, even when the CBEC rate remained as high as 57.7% in 2010. **CONCLUSIONS:** Although health policies were designed to increase emergent care resources across subregions, the differences in CBEC flow among subregions did not decrease significantly from 2000 to 2010. Nevertheless, the emergent care in subregions with high CBEC flows improved substantially because of the increase in emergent care capacity. However, the CBEC flow remained high, indicating that allocating more emergent care resources to these subregions is warranted.

PHS125
WHERE DO VETERANS RECEIVE THEIR CARE FOR NON-TRAUMATIC BONE FRACTURES?

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OBJECTIVES: We examined the relationship between distance to the nearest Veterans Affairs Medical Center (VAMC) and care site for elderly male Veterans who were dually eligible to receive Veterans Affairs (VA) and Medicare services. **METHODS:** We used a cross-sectional design to identify male Veterans (age ≥70) with a non-traumatic hip, wrist, or spine fracture from all male Veterans who received care in the VA between 2002 and 2008 with a recent history of VA utilization. Patient characteristics and ZIP codes were from VA administrative and clinical datasets. Fractures were identified using VA and Medicare datasets and categorized as being treated in the VA if the first diagnosis code for a fracture occurred in the VA dataset, or non-VA if first in the Medicare dataset. Distance was calculated as miles between the patient's residence ZIP code and the nearest VAMC. Logistic regression was used to estimate the effect of distance on VA treatment for fracture while controlling for age, race, comorbidity index, and geographic characteristics. **RESULTS:** Of the 146,586 Veterans with fracture included in our study, 24,003 were treated in the VA system. Patients that lived further from a VAMC were less likely to have their fracture treated at the VA than those who were located within 5 miles of a VAMC (adjusted OR = 0.77 (0.73-0.81) for 5-10 miles, continuing to 0.24 (0.23-0.26) for >40 miles). Veterans that were older, white, or had a lower comorbidity index were more likely to receive care outside of the VA system. Veterans with a wrist fracture were more likely to receive VA treatment than those with hip or vertebral fractures. **CONCLUSIONS:** Among elderly males with a history of VA system utilization, greater distance to the nearest VAMC was significantly associated with a decreased likelihood of using the VA for fracture treatment.

PHS126
DISPARITIES IN RISK OF BANKRUPTCY AMONG PATIENTS DIAGNOSED WITH CANCER

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OBJECTIVES: Cancer patients are substantially more likely to file for bankruptcy than persons without cancer, but little is known about the determinants of bankruptcy among the general population of cancer survivors. **METHODS:** In order to better understand whether disparities in risk for bankruptcy exist among patients with cancer, we conducted a population-based cohort study of adults diagnosed with a first-primary invasive cancer in the Western Washington Surveillance Epidemiology and End Results (SEER) region between 1995 and 2009 and linked their cancer registry data to records of the US Bankruptcy Court. Using multivariable adjusted competing risk regression models, we estimated the hazard ratio (HR) and 95% confidence interval (CI) for the association between various sociodemographic and tumor characteristics and bankruptcy. **RESULTS:** Of 231,673 persons diagnosed with cancer, a total of 4,728 (2.0%) filed for bankruptcy. Compared to non-Hispanic White patients, African Americans (HR 1.88, 95% CI 1.64-2.16), Hispanics (HR 1.82, 95% CI 1.49-2.22), and American Indian/Alaska Native (HR 1.63, 95% CI 1.28-2.07) patients were all at substantially higher risk of bankruptcy. In addition, individuals living in higher income areas, males, and married cancer patients were at reduced risk of filing for bankruptcy, compared to females and unmarried patients respectively. **CONCLUSIONS:** The financial burden of cancer may disproportionately result in bankruptcy filings for minorities and cancer patients of lower socioeconomic position. These results highlight the need for policy changes protecting the financial health of cancer survivors.